State Options to Implement Provisions of the Eligibility and Enrollment Final Rule Post-OBBBA

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This chart provides information about the status of each provision of the Eligibility and Enrollment Final Rule following the enactment of the "One Big Beautiful Bill" Act, which partially blocks implementation and enforcement of some of the rule until September 30, 2034. It also provides an overview of the options states have to implement the rule's protections and streamlining provisions even though parts of the Final Rule are blocked.

Provisions in effect following OBBBA enactment are highlighted in **green**. Provisions not in effect/blocked by OBBBA are highlighted in **red**. Provisions that are partially in effect are highlighted in **yellow**.

Facilitating Medicaid Enrollment

E&E Rule Requirement	Post-OBBBA Status and State Options
Facilitate enrollment by allowing Medically Needy individuals to deduct prospective medical expenses (42 C.F.R. §§ 435.831 and 436.831).	**This provision is in effect.** Individuals seeking to qualify for Medicaid through a Medically Needy pathway can meet their spend-down requirements by projecting "reasonably constant and predictable" community-based services if a state elects this option.
Application of primacy of electronic verification and reasonable compatibility standard for resource information (42 C.F.R. §§ 435.952 and 435.940).	**This provision is in effect.** States must use the same reasonable compatibility standard for resources as income.
Streamlined verification of citizenship and identity (42 C.F.R. §§ 435.407 and 457.380).	**This provision is not in effect.** States must require additional proof of identity on top of a successful match through a state vital statistics office or the Department of Homeland Security's SAVE program.

Promoting Enrollment and Retention of Eligible Individuals

Aligning non-MAGI enrollment and renewal requirements with MAGI policies (42 C.F.R. §§ 435.907(c)(4) and (d) and 435.916)

E&E Rule Requirement	Post-OBBBA Status and State Options
Application: States must provide non-MAGI applicants 15 calendar days at minimum to respond to requests for additional information (30 for MSP applicants).	**This provision is not in effect.** The 15-day requirement is removed. States could still elect to impose this (or a longer) response timeline because there is no restriction against it.
Renewal: States must provide non-MAGI enrollees 30 calendar days at minimum to respond to information requests or return the renewal form. The 30 days begins on the date the state sends the form.	**This provision is not in effect.** As of June 2024, the vast majority of states were already providing 30 days for non-MAGI enrollees to return renewal info. States could elect to roll back this timeline. In that case, the state would revert to a "reasonable" timeframe for non-MAGI renewals.
Post-termination: States must provide a 90-day reconsideration period for non-MAGI enrollees who return their renewal form after the end of their eligibility period and have their eligibility terminated for failure to return the form. During this period, the state must treat receipt of the renewal form as a new application and reconsider the individual's eligibility.	**This provision is not in effect.** As of June 2024, the vast majority of states provided non-MAGI enrollees a 90-day reconsideration period.
Barring a change in circumstances, states must not renew eligibility more frequently than once every 12 months for non-MAGI (or as often as every 6 months for QMB enrollees).	**This provision is not in effect.** As of June 2024, all states were performing annual renewals for non-MAGI populations. This option should not be affected by OBBBA, which only applies the 6-month renewal period to some expansion enrollees. However, states can perform more frequent renewals for non-MAGI enrollees.
States must accept non-MAGI applications and supplemental forms through any	**This provision is not in effect.** States retain the option to implement it, but it is not required.

modality available and offered by the state at application.	
States cannot require in-person interviews for non-MAGI applications/renewals (including phone or other virtual interviews).	**This provision is not in effect.** As of June 2024, no state was conducting in-person interviews for non-MAGI renewals as of June 2024. States retain the option not to require in-person interviews but could reinstate them for non-MAGI populations.
If a non-MAGI enrollee's eligibility cannot be renewed based on information already available to the state, the state must provide a pre-populated renewal form containing information available to the state.	**This provision is not in effect.** As of June 2024, 38 states provided pre-populated renewal forms to non-MAGI beneficiaries. States could roll back this option.

Changes in circumstances (42 C.F.R. §§ 435.916, 435.919, and 457.344)

E&E Rule Requirement	Post-OBBBA Status and State Options
States must promptly redetermine eligibility when reliable information about a change in circumstances is received. "Reliable information" can include returned mail, information from the USPS NCOA database and Medicaid managed care plans, or other data sources that have been identified by the agency and approved by CMS.	**This provision is not in effect.** The prior version of 42 C.F.R. § 435.916 still requires a prompt redetermination of eligibility when information about a change in an enrollee's circumstances that may affect their eligibility is received, but does not define "reliable information."
States must review information as described in their verification plans before contacting the enrollee to request information and provide 30 calendar days at a minimum to respond from the date a request for information is sent.	**This provision is not in effect.** 42 C.F.R. § 435.919 is blocked in its entirety. States can provide the 30-day response time, but it is not required.
States must limit the request to only information related to the change in circumstance.	**This provision is not in effect, but** the prior version of 42 C.F.R. § 435.916 provides that the "agency may request from beneficiaries only the information needed to renew eligibility," without distinguishing between MAGI and non-MAGI.

States must accept information returned by enrollees through any modality available and offered by the state, including phone, mail, in-person, and/or web-based modalities.	**This provision is not in effect.** States can adopt it at their option, but are not required to.
If a reported change would result in additional medical assistance and it was reported by the enrollee, states must verify pursuant to the verification plan. If the report was obtained from a 3rd party data source, states may verify the change with the enrollee (but do not have to). The state may not terminate the enrollee for failure to respond, and must maintain the status quo for the rest of the eligibility period.	**This provision is not in effect.** 42 C.F.R. § 435.919 is blocked in its entirety. For changes that would result in additional medical assistance, it is unclear whether states could choose not to act on those changes and maintain the status quo if the enrollee does not respond.
If a reported change would adversely impact eligibility and it was obtained from a 3rd party data source, states must give the enrollee an opportunity to provide additional information to confirm/dispute the change. States can only take action after the 30-day response period has passed.	**This provision is not in effect.** 42 C.F.R. § 435.919 is blocked in its entirety. However, 42 C.F.R. § 435.952(d) (which was not changed by the E&E Rules) provides that benefits may not be denied or terminated based on eligibility information unless the agency has sought additional information and provided proper notice and hearing rights.
States must allow a 90-day reconsideration period for enrollees who are terminated for failure to return change in circumstances information. If the state receives additional information within the reconsideration period, it must reopen the case and process eligibility within the normal timeframes.	**This provision is not in effect.** 42 C.F.R. § 435.919 is blocked in its entirety. States may provide a reconsideration period for enrollees who are terminated for failure to return change in circumstances information, but it is not mandatory.

Timely determination and redetermination of eligibility (42 C.F.R. §§ 435.907, 435.912, 457.340(d), and 457.1170)

Broad Regulatory Changes

E&E Rule Requirement	Post-OBBBA Status and State Options
42 C.F.R. § 435.912	All parts of the regulation pertaining to renewals and redeterminations are blocked.
42 C.F.R. § 457.340(d)	**These regulatory changes are in effect.** All terms of 42 C.F.R. § 435.912 apply to CHIP, except certain parts of 42 C.F.R. § 435.912 pertaining to timelines for completing renewals and redeterminations when states must consider other eligibility bases (which are blocked anyway). 42 C.F.R. § 457.340(d)(3), which pertained to CHIP waiting periods, is eliminated (see CHIP eligibility changes below).
42 C.F.R. § 457.1170	States are not required to ensure continuation of benefits and review rights when a CHIP eligibility determination has not been made timely.

Application Timeframes

E&E Rule Requirement	Post-OBBBA Status and State Options
Application processing (non-disability): 45 days, including any requests for information (also applies to individuals transferred to Medicaid, CHIP, or BHP). **Application processing (disability):** 90 days, including requests for information (also applies to individuals transferred to Medicaid who must undergo a disability determination).	**This provision is not in effect.** Per 42 C.F.R. § 435.912, the 45-day/90-day application processing deadlines still apply. The explicit requirement that these timelines apply to Medicaid eligibility determinations resulting from transfers from other insurance affordability programs (IAPs) is eliminated. However, the prior version of 42 C.F.R. § 435.912(b)(3) still requires states to establish timeliness standards for determining Medicaid eligibility for individuals transferred from other IAPs, including at initial application, periodic renewal, or due to a change in circumstances.

States must provide at least 15 calendar days to provide information to complete the application. If the applicant is denied for failing to return the information but provides it within 90 calendar days of the denial, the state must restart the eligibility determination.	**This provision is not in effect.** States have the option to provide the 15-day minimum to return information and the 90-day reconsideration period, but they are not mandatory.

Renewal Timeframes

E&E Rule Requirement	Post-OBBBA Status and State Options
At renewal, states must provide enrollees 30 calendar days to return a renewal form and/or requested information.	**This provision is not in effect.** All explicit requirements in 42 C.F.R. § 435.912 that pertain to redeterminations of eligibility are blocked. The prior version of the regulation does not limit what states can do beyond the minimal requirements contained in the regulation, but the additional protections of the Final Rule are not mandatory.
Renewals for enrollees in a non-disability category remaining in the same eligibility category must be completed before the end of the eligibility period as long as the state has all needed information at least 30 calendar days before the end of the eligibility period. If the state needs information from the enrollee or receives all the information with less than 30 calendar days before the end of the eligibility period, then the state has until the end of the month following receipt of the information to process the enrollment.	**This provision is not in effect.** All explicit requirements in 42 C.F.R. § 435.912 that pertain to redeterminations of eligibility are blocked. The prior version of the regulation does not limit what states can do beyond the minimal requirements contained in the regulation, but the additional protections of the Final Rule are not mandatory.
Renewals for enrollees in a non-disability eligibility category must be completed within 45 calendar days, including requests for information.	**This provision is not in effect.** All explicit requirements in 42 C.F.R. § 435.912 that pertain to redeterminations of eligibility are blocked. The prior version of the regulation does not limit what states can do beyond the minimal requirements contained in the

	regulation, but the additional protections of the Final Rule are not mandatory.
Renewals for enrollees in a disability eligibility category must be completed within 90 calendar days, including requests for information.	**This provision is not in effect.** All of the explicit requirements in 42 C.F.R. § 435.912 that pertain to redeterminations of eligibility are blocked. The prior version of the regulation does not limit what states can do beyond the minimal requirements contained in the regulation, but the additional protections of the Final Rule are not mandatory.
States must provide a 90-day reconsideration period for procedural terminations. If information or forms are received within that period, the state must process the redetermination within either 45 or 90 days (depending on eligibility category).	**This provision is not in effect.** All explicit requirements in 42 C.F.R. § 435.912 that pertain to redeterminations of eligibility are blocked. The prior version of the regulation does not limit what states can do beyond the minimal requirements contained in the regulation, but the additional protections of the Final Rule are not mandatory.

Change in Circumstances Timeframes

E&E Rule Requirement	Post-OBBBA Status and State Options
The state must provide enrollees at least 30 calendar days to respond to requests for information, starting on the date the request is sent.	**This provision is not in effect.** 42 C.F.R. § 435.919 is blocked in its entirety. There is nothing prohibiting states from implementing this protection, but it is not mandatory.
The state has until the end of the month in which an anticipated change in eligibility occurs to process an enrollee's eligibility redetermination, *unless* the enrollee submits all needed information less than 30 calendar days before the change. In that case, the state has until the end of the month following the anticipated change.	**This provision is not in effect.** The prior version of 42 C.F.R. § 435.912 does not limit what states can do beyond the minimal requirements contained in the regulation, but the additional protections of the Final Rule are not mandatory.
In cases where a change in circumstances is reported and the state does not need more information from the enrollee, the state has until the end of the month that occurs 30	**This provision is not in effect.** The prior version of 42 C.F.R. § 435.912 does not limit what states can do beyond the minimal requirements contained in the regulation, but

calendar days after the change to determine whether the enrollee remains eligible.	the additional protections of the Final Rule are not mandatory.
In cases where a change in circumstances is reported but the state needs more information from the enrollee, the state has until the end of the month that is 60 calendar days after the change is reported to determine whether the enrollee remains eligible.	**This provision is not in effect.** The prior version of 42 C.F.R. § 435.912 does not limit what states can do beyond the minimal requirements contained in the regulation, but the additional protections of the Final Rule are not mandatory.

Agency action on updated address information (42 C.F.R. §§ 435.919 and 457.344)

E&E Rule Requirement	Post-OBBBA Status and State Options
When an individual's address cannot be confirmed via a reliable data source, states must make a "good faith" effort to contact them, and giving at least 30 days for the individual to respond with their updated contact information.	**This provision is not in effect.** 42 C.F.R. §§ 435.919 and 457.344 are both blocked in their entirety. It does not appear that states would be limited from developing similar requirements as a matter of policy but they are not required to do any of this.
When a state receives returned mail with an in-state forwarding address from a reliable source, it must update the individual's record and notify the individual of the change. If the source is not considered reliable, the state must check its Medicaid Enterprise System and review other reliable sources according to the verification plan and, if the address is confirmed, update it without further verification. If the address is not confirmed, then the state must make a "good faith effort" to contact the individual and allow them 30 calendar days to respond, not terminate them for failing to respond, and not use the information to update their case record if they do not respond.	**This provision is not in effect.** 42 C.F.R. §§ 435.919 and 457.344 are both blocked in their entirety. It does not appear that states would be limited from developing similar requirements as a matter of policy (for instance, Minnesota had already developed some strategies for addressing returned mail prior to the E&E Rules), but they are not required to do any of this.
When a state receives returned mail with an out-of-state forwarding address, it must check reliable sources to confirm the updated address information, make a "good	**This provision is not in effect.** 42 C.F.R. §§ 435.919 and 457.344 are both blocked in their entirety. It does not appear that states would be limited from developing similar

faith effort" to contact the individual, and give them 30 calendar days to respond. If they do not respond, the state must provide an advance termination notice and fair hearing rights after the 30-day period.	requirements as a matter of policy, but they are not required to do any of this.
When a state receives returned mail with no forwarding address, it must check the MES and reliable sources to confirm updated address information. If updated information cannot be obtained, the state must make a "good faith effort" to contact the individual, and either move them to FFS coverage or take steps to terminate or suspend coverage. If the state opts to terminate coverage, notice and fair hearing rights must be provided electronically or to the LKA. If the enrollee's address becomes known before the eligibility period expires, the state must reinstate coverage without requiring additional verification of eligibility.	**This provision is not in effect.** 42 C.F.R. §§ 435.919 and 457.344 are both blocked in their entirety. It does not appear that states would be limited from developing similar requirements as a matter of policy (for instance, Minnesota had already developed some strategies for addressing returned mail prior to the E&E Rules), but they are not required to do any of this.

Transitions between Medicaid, CHIP, and BHP agencies (42 C.F.R. §§ 431.10, 435.1200, 457.340, 457.348, 457.350, and 600.330)

E&E Rule Requirement	Post-OBBBA Status and State Options
Medicaid and separate CHIPs must make eligibility determinations on behalf of one another, accept eligibility determinations made by the other program, transition individuals to the IAP they are determined eligible or potentially eligible for based on available data, and provide a single combined notice to all members of a household with information about each individual's eligibility status for each applicable IAP.	**These provisions are partially in effect.** Single State Agencies can permit their separate CHIP and BHP agencies to make Medicaid eligibility determinations. Separately, states must seamlessly transition individuals between Medicaid and CHIP when the Medicaid and/or CHIP agencies determine that an enrollee is eligible for the other program, accept eligibility determinations for MAGI Medicaid made by a separate CHIP agency, transfer files between IAPs as appropriate, and provide a single combined notice.

Eliminating Barriers to Access in Medicaid

E&E Rule Requirement	Post-OBBBA Status and State Options
Remove optional limitation on the number of reasonable opportunity periods (42 C.F.R. §§ 435.956 and 457.380).	**This provision is in effect.** States must provide a reasonable opportunity period to individuals who have attested to their citizenship or "satisfactory immigration status" during which the state furnishes Medicaid services to that individual while working to verify their citizenship or immigration status. States may not limit the number of reasonable opportunity periods.
Remove requirement to apply for other benefits (42 C.F.R. §§ 435.608 and 436.608).	**This provision is in effect.** States may not require applicants or enrollees to apply for other benefits as a condition of Medicaid eligibility.

Recordkeeping (42 C.F.R. §§ 431.17, 435.914, and 457.965)

E&E Rule Requirement	Post-OBBBA Status and State Options
Clarifies requirement that state agencies maintain records in an electronic format, specific information to be retained, minimum retention periods, and requirements for making records available outside of the agency.	**This provision is in effect.** States must maintain specific information mandated at 42 C.F.R. § 431.17(b) in an electronic format for at least three years. Case documentation requirements apply to eligibility redeterminations. Similar requirements are implemented for CHIP.

Eliminating Access Barriers in CHIP and BHP

E&E Rule Requirement	Post-OBBBA Status and State Options
Prohibition on premium lock-out periods (42 C.F.R. §§ 457.570 and 600.525(b)(2)), waiting periods (42 C.F.R. §§ 457.65, 457.340, 457.350, 457.805, and 457.810), and annual and lifetime limits (42 C.F.R. § 457.480) in CHIP.	**These provisions are in effect.** As of June 2024, states may not impose new premium lockout periods or waiting periods in their CHIPs. Any existing premium lockout periods, waiting periods, or annual/lifetime limits must be phased out by June 2025.